

		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026328

Facility Name: Oakview Heights Continuous Care & Rehabilitation Center

Address: 1320 West Ninth Street Mt. Carmel 62863
Number City Zip Code

County: Wabash

Telephone Number: (618) 263-4337 Fax # (618) 262-7080

IDPA ID Number: 371104153001

Date of Initial License for Current Owners: 06/01/81

Type of Ownership:

<input checked="" type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input checked="" type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code	501(c)(3)	<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin Telephone Number: (217) 258-8888
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 09/01/2000 to 08/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) SEE ACCOUNTANTS' COMPILATION REPORT	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606	
	(Telephone) (312) 634-3400 Fax # (312) 634-5518	
	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center

0026328 Report Period Beginning: 09/01/2000 Ending: 08/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>160</u>	Skilled (SNF)	<u>160</u>	<u>58,400</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>160</u>	TOTALS	<u>160</u>	<u>58,400</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,828</u>	<u>4,156</u>	<u>1,224</u>	<u>10,208</u>	8
9	SNF/PED					9
10	ICF	<u>14,301</u>	<u>7,161</u>		<u>21,462</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,129</u>	<u>11,317</u>	<u>1,224</u>	<u>31,670</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 54.23%

D. How many bed-hold days during this year were paid by Public Aid?

NA (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☒ NO ☐ Non-allowable costs have been
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/01/81

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 06/01/81 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 20 and days of care provided 1,224

Medicare Intermediary AdminaStar Federal (Indianapolis)

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 08/31/01 Fiscal Year: 08/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Oakview Heights Continuous Care & Rehabi # 0026328 Report Period Beginning: 09/01/2000 Ending: 08/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	193,027	40,599	8,319	241,945		241,945	(8,283)	233,662			1
2	Food Purchase		167,523		167,523		167,523	(4,773)	162,750			2
3	Housekeeping	86,553	29,515		116,068		116,068		116,068			3
4	Laundry	14,598	1,877	59,957	76,432		76,432		76,432			4
5	Heat and Other Utilities			91,856	91,856		91,856		91,856			5
6	Maintenance	48,205	31,069	32,637	111,911		111,911		111,911			6
7	Other (specify):*											7
8	TOTAL General Services	342,383	270,583	192,769	805,735		805,735	(13,056)	792,679			8
	B. Health Care and Programs											
9	Medical Director			15,432	15,432		15,432		15,432			9
10	Nursing and Medical Records	931,847	126,108	5,531	1,063,486		1,063,486		1,063,486			10
10a	Therapy		12,889	146,039	158,928		158,928		158,928			10a
11	Activities	39,962	861		40,823		40,823		40,823			11
12	Social Services	25,082		4,777	29,859		29,859		29,859			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	996,891	139,858	171,779	1,308,528		1,308,528		1,308,528			16
	C. General Administration											
17	Administrative	117,787			117,787		117,787		117,787			17
18	Directors Fees											18
19	Professional Services			43,940	43,940		43,940		43,940			19
20	Dues, Fees, Subscriptions & Promotions			13,275	13,275		13,275	(20)	13,255			20
21	Clerical & General Office Expenses	50,694	9,526	45,287	105,507		105,507		105,507			21
22	Employee Benefits & Payroll Taxes			203,573	203,573		203,573		203,573			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,562	2,562		2,562		2,562			24
25	Other Admin. Staff Transportation			5,371	5,371		5,371	(1,233)	4,138			25
26	Insurance-Prop.Liab.Malpractice			47,440	47,440		47,440		47,440			26
27	Other (specify):*											27
28	TOTAL General Administration	168,481	9,526	361,448	539,455		539,455	(1,253)	538,202			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,507,755	419,967	725,996	2,653,718		2,653,718	(14,309)	2,639,409			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7**	8			
30	Depreciation			118,870	118,870		118,870		118,870			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			119,129	119,129		119,129	(383)	118,746			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,918	13,918		13,918		13,918			35
36	Other (specify):*											36
37	TOTAL Ownership			251,917	251,917		251,917	(383)	251,534			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		21,101		21,101		21,101		21,101			39
40	Barber and Beauty Shops			9,231	9,231		9,231		9,231			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,600	87,600		87,600		87,600			42
43	Other (specify):* Nonallowable costs			75,671	75,671		75,671	(75,671)				43
44	TOTAL Special Cost Centers		21,101	172,502	193,603		193,603	(75,671)	117,932			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,507,755	441,068	1,150,415	3,099,238		3,099,238	(90,363)	3,008,875			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Cente # 0026328 Report Period Beginning: 09/01/2000 Ending: 08/31/2001

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,343)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(383)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,459)	43		24
25	Fund Raising, Advertising and Promotional	(12,998)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,555)	43		28
29	Other-Attach Schedule <u>See Supl pg 1</u>	(49,625)	var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (90,363)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (90,363)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

08/31/2001

[illegible]

Summary B

Facility Name & ID Number	Oakview Heights Continuous Care & Rehabilitation Center	#	0026328	Report Period Beginning:	09/01/2000	Ending:	08/31/2001
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule of Board of Directors						
	None	N/A				
No directors directly provided services or had interests in entities that had business transactions with the facility.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V				N/A				4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Oakview Heights Continuous Care & Rehab # 0026328 Report Period Beginning: 09/01/2000 Ending: 08/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4		N/A									4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/2000 Ending: 8/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6			N/A						6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Old National Bank		X	Purchase of van	\$426.00	09/01/95	\$ 23,548	\$	09/01/00	0.0895	\$ 84	1	
2	Fifth/Third Bank		X	Mortgage	\$15,000.00	10/01/98	1,500,000	1,297,878	10/30/01	0.0675	111,854	2	
3	United Leasing		X	Lease obligation-phone sys.	\$475.00	08/24/98	28,496	10,923	08/24/03	0.0850	1,861	3	
4	Galaxy Medical Products		X	Lease obl. - air mattress	\$750.00	05/01/01	4,500	1,500	10/31/01			4	
5												5	
	Working Capital												
6	Gen'l Baptist-Campbell, MO	X		Line of Credit	Line of Credit	10/31/96	8,300		08/31/01	N/A		6	
7	Gen'l Baptist-Campbell, MO	X		Line of Credit	Line of Credit	11/15/84	10,000		08/31/01	N/A		7	
8	Fifth/Third Bank		X	Line of Credit	Line of Credit	11/01/98	100,000	100,000	10/30/01	0.0675	5,330	8	
9	TOTAL Facility Related				\$16,651.00		\$ 1,674,844	\$ 1,410,301			\$ 119,129	9	
	B. Non-Facility Related*												
10								Less: Interest income offset			(383)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (383)	14	
15	TOTALS (line 9+line14)						\$ 1,674,844	\$ 1,410,301			\$ 118,746	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.
TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1996

1997

1998

1999

2000

8

9

10

11

12

FOR OHF USE ONLY

13

14

15

16

FROM R. E. TAX STATEMENT FOR 2000

PLUS APPEAL COST FROM LINE 5

LESS REFUND FROM LINE 6

AMOUNT TO USE FOR RATE CALCULATION

\$

\$

\$

\$

13

14

15

16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oakview Heights Continuous Care & Rehabilitation Cente COUNTY Wabash

FACILITY IDPH LICENSE NUMBER 0026328

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

	(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
	Tax Index Number	Property Description	Total Tax	
1.			\$	\$
2.	N/A - Not-for-profit facility		\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,602

B. General Construction Type: Exterior Concrete/sandstone Frame Steel

Number of Stories One

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident use	352,863	1981	\$ 119,216	1
2	Resident use	270,630	1994	60,000	2
3	TOTALS	623,493		\$ 179,216	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	160		1981	1981	\$ 1,310,463	\$ 46,926	40	\$ 46,926	\$	\$ 946,898	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1984	5,654		7			5,654	9
10	Building Improvements			1985	9,568		7			9,568	10
11	Building Improvements			1984	6,143		10			6,143	11
12	Building Improvements			1984	6,237		10			6,237	12
13	Building Improvements			1994	2,914	291	10	291		2,209	13
14	Land Improvements			1982	14,363		10			14,363	14
15	Roof			1996	68,042	2,268	30	2,268		11,529	15
16	Walk-in Freezer			1996	24,497	3,500	7	3,500		18,415	16
17											17
18	Awning			1997	8,300	533	15	533		2,172	18
19	Air Conditioner Units			1997	7,687	1,096	7	1,096		5,089	19
20	Roof (final)			1997	11,450	382	30	382		1,846	20
21	Door Knobs/Locks			1998	3,448	494	7	494		1,973	21
22	Electrical - new wiring			1998	23,632	945	25	945		3,623	22
23	Drywall/Labor			1998	21,125	1,408	15	1,408		5,161	23
24	Carpet			1998	7,927	1,132	7	1,132		3,585	24
25	Awning			1998	3,694	528	7	528		1,716	25
26	Sign			1998	2,000	133	15	133		422	26
27	Wallpaper			1998	2,435	349	7	349		1,220	27
28	Plastic Coat - Roof, Wings			1998	12,500	417	7	417		1,469	28
29	Lavatory Faucets (12)			1998	4,470	298	30	298		1,093	29
30	Overhead Lights (9)			1998	921	61	15	61		224	30
31	Exit Sign			1998	449	30	15	30		110	31
32	Chandeliers - Hall			1998	1,530	102	15	102		391	32
33	Plumbing			1998	9,003	600	15	600		2,100	33
34	Gazebo			1998	3,495	350	10	350		1,370	34
35	Parking Lot Repavement			1998	12,677	1,268	10	1,268		4,966	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Landscaping	1998	\$ 8,837	\$ 589	15	\$ 589	\$	\$ 2,160	37
38	Ditch Work	1998	700	47	15	47		183	38
39	Exterior Sign	1998	3,200	213	15	213		622	39
40	Carpet, Window Treatments	1998	30,904	3,090	10	3,090		9,013	40
41	Fuel Tank	1999	8,935	596	15	596		1,391	41
42	Wall Paper	1999	4,135	276	15	276		667	42
43	Paking Lot Resurfacing	1999	3,336	667	15	667		1,556	43
44	Landscaping	1999	976	65	15	65		157	44
45									45
46	Land improvements	2000	646	36	15	36		54	46
47	Kitchen tile	2000	4,230	423	10	423		599	47
48	Britlingham air & water	2000	1,992	285	7	285		309	48
49	Handrails	2000	3,819	546	7	546		473	49
50									50
51	Tile - Wing 7	2000	3,753	360	7	360		360	51
52	Fire doors	2000	4,861	365	10	365		365	52
53	Landscaping	2001	380	15	15	15		15	53
54	North side heaters	2001	6,090	507	7	507		507	54
55	Water heater	2001	15,195		7				55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,686,613	\$ 71,191		\$ 71,191	\$	\$ 1,077,977	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$444,198	\$44,818	\$44,818	\$	Various	\$265,375	71
72	Current Year Purchases	33,419	2,861	2,861		Various	2,861	72
73	Fully Depreciated Assets	218,245				Various	218,245	73
74								74
75	TOTALS	\$695,862	\$47,679	\$47,679	\$		\$486,481	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility use	1986 Mazda truck	1992	\$4,474	\$	\$	\$	5	\$4,474	76
77	Facility use	1996 Chevrolet van	1995	23,548				5	23,548	77
78										78
79										79
80	TOTALS			\$28,022	\$	\$	\$		\$28,022	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$2,589,713	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$118,870	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$118,870	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,592,480	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number	Oakview Heights Continuous Care & Rehabilitation Center #	0026328	Report Period Beginning:	09/01/2000	Ending: 08/31/2001
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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ **YES** ☐ **NO** **Terms:** *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

16. Rental Amount for movable equipment: \$ 13,918 **Description:** Copiers (2) - 12,628; Dishwasher - 1,285; PT equipment - 5
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$		17
18			N/A		18
19					19
20					20
21	TOTAL		\$		21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. **/2002** **\$**

13. _____ /2003 \$ _____

14. /2004 \$

*** If there is an option to buy the building, please provide complete details on attached schedule.**

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

It is the policy of this facility to only hire certified nurses aides
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(2), (3)	hrs	\$	1,057	\$ 11,505	\$ 128	1,057	\$ 11,633	1
2	Licensed Speech and Language Development Therapist	10A(2), (3)	hrs		3,281	37,166	128	3,281	37,294	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), (3)	hrs		10,756	97,368	12,633	10,756	110,001	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				21,101		21,101	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	15,094	\$ 146,039	\$ 33,990	15,094	\$ 180,029	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/2000 Ending: 08/31/2001
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 08/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$		1
2	Cash-Patient Deposits	8,882	8,882	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>335,758</u>)	484,810	484,810	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,969	8,969	6
7	Other Prepaid Expenses	41,126	41,126	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 543,787	\$ 543,787	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	179,216	179,216	13
14	Buildings, at Historical Cost	1,641,203	1,641,203	14
15	Leasehold Improvements, at Historical Cost	45,410	45,410	15
16	Equipment, at Historical Cost	723,884	723,884	16
17	Accumulated Depreciation (book methods)	(1,592,480)	(1,592,480)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 997,233	\$ 997,233	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,541,020	\$ 1,541,020	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 219,423	\$ 219,423	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,882	8,882	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,570	26,570	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,981	29,981	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	231	231	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Supl pg 1</u>	98,226	98,226	36
37	<u>Short-Term Notes Payable</u>	1,299,378	1,299,378	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,682,691	\$ 1,682,691	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	110,923	110,923	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 110,923	\$ 110,923	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,793,614	\$ 1,793,614	46
47	TOTAL EQUITY (page 18, line 24)	\$ (252,594)	\$ (252,594)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,541,020	\$ 1,541,020	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (651,525)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (651,525)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(466,187)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) Debt Cancelation	865,118	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 398,931	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (252,594)	24 *

Operating entity only
* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation # 0026328 Report Period Beginning: 09/01/2000 Ending: 08/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,502,265	1
2	Discounts and Allowances for all Levels	(388)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,501,877	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	7,411	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	43,274	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 50,685	23
	D. Non-Operating Revenue		
24	Contributions	39,424	24
25	Interest and Other Investment Income***	383	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 39,807	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other income (See Supl pg 1)	14,928	28
28a	Gain on Sale of Land (See Supl pg 1)	25,754	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 40,682	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,633,051	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	805,735	31
32	Health Care	1,308,528	32
33	General Administration	539,455	33
	B. Capital Expense		
34	Ownership	251,917	34
	C. Ancillary Expense		
35	Special Cost Centers	106,003	35
36	Provider Participation Fee	87,600	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,099,238	40
41	Income before Income Taxes (line 30 minus line 40)**	(466,187)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (466,187)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 43,285	\$ 20.81	1
2	Assistant Director of Nursing	2,080	2,080	33,977	16.34	2
3	Registered Nurses	14,994	14,994	216,799	14.46	3
4	Licensed Practical Nurses	15,719	15,719	179,417	11.41	4
5	Nurse Aides & Orderlies	58,127	58,127	458,369	7.89	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	17,271	8.30	9
10	Activity Assistants	2,856	2,856	22,691	7.95	10
11	Social Service Workers	2,080	2,080	25,082	12.06	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	26,083	12.54	13
14	Head Cook	2,080	2,080	14,560	7.00	14
15	Cook Helpers/Assistants	25,604	25,604	129,732	5.07	15
16	Dishwashers	4,080	4,080	22,652	5.55	16
17	Maintenance Workers	6,240	6,240	48,205	7.73	17
18	Housekeepers	12,207	12,207	86,553	7.09	18
19	Laundry	2,080	2,080	14,598	7.02	19
20	Administrator	2,080	2,080	78,840	37.90	20
21	Assistant Administrator	2,080	2,080	38,947	18.72	21
22	Other Administrative					22
23	Office Manager	2,080	2,080	26,344	12.67	23
24	Clerical	4,184	4,184	24,350	5.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,811	164,811	\$ 1,507,755 *	\$ 9.15	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 8,319	1(3)	35
36	Medical Director	Monthly	15,432	9(3)	36
37	Medical Records Consultant	Monthly	2,020	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,680	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	3,577	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,028		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5			N/A										
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

Life Services Network of Illinois - 4,282
- (3) Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

7.75
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 26,336

Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- (9) Are you presently operating under a sublease agreement?

YES

X

NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.

\$ 87,600

This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ None

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 4,773
- (16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

None

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

Wilcox, McGuire & Wrye

The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?

No

If no, please explain.

Audit not yet complete.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.
- SEE ACCOUNTANTS' COMPILATION REPORT

Oakview Heights Continuous Care & Rehab Center
Facility #: 0026328
09/01/99 - 08/31/00

Supplementary Information

Page 3: Other Admin. Staff Transportation - Line 25

Employee mileage reimbursement	3,368
Travel to meeting in Little Rock, AR	1,233
Moving expense reimbursed - D. Price	770
	<u>5,371</u>
Less: Non-allowable out of state travel	<u>(1,233)</u>
	<u>4,138</u>

Page 5: Adjustment Detail - Line 29 - Other

		<u>Ref</u>
Resident expenses	(10,974)	43
Offset vending income	(8,283)	1
Offset food income	(4,773)	2
Disallow overpayments due IDPA	(24,342)	43
Disallow nonallowable dues	(20)	20
Disallow out-of-state travel	<u>(1,233)</u>	24
	<u>(49,625)</u>	

Page 6 - Schedule VII - Related Parties

Board of Directors:

Terry Yancy	President
Gary Underwood	Vice Pres
Ronnie Stevens	Treasurer
Will Schwarzlose	Director
Roy Biggerstaff	Secretary
Kenneth Curtis	Director
Sharon Russon	Director
James Cowsert	Director
Cecil Winberry	Director
Bob Taylor	Director
Harold Hughes	Director
David Whitten	Director
Bill Willis	Director
Harry Reed	Director
Dan Sitze	Director

Page 17: Other Current Liabilities - Line 36

IDPA Overpayments Payable	12,171
Advance Billing-Deferred	<u>86,055</u>
	<u>98,226</u>

Page 19: Other Income - Line 28

Meal & Vending Machine	<u>14,928</u>
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Page 19: Other Income - Line 28a

Gain on Sale of Asset:	
Proceeds of Sale	39,000
Less: Basis in Land Sold	<u>(13,246)</u>
Gain	<u>25,754</u>

Page

1

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10 Attachment of Real Estate Bill and fill out form

11

12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached

13

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15

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19 The bottom right side of page under **, you must write in any comments

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RECONCILIATION REPORT

Oakview Heights Contini

11:48 AM

11/08/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-90,363	equal to	-90,363	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	118,746	equal to	118,746	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	118,870	equal to	118,870	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	13,918	equal to	13,918	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	158,928	equal to	158,928	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	33,990	equal to	33,990	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	805,735	equal to	805,735	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,308,528	equal to	1,308,528	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	539,455	equal to	539,455	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	251,917	equal to	251,917	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	106,003	equal to	106,003	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	87,600	equal to	87,600	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	931,847	equal to	931,847	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	39,962	equal to	39,962	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	25,082	equal to	25,082	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	193,027	equal to	193,027	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	48,205	equal to	48,205	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	86,553	equal to	86,553	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	14,598	equal to	14,598	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	117,787	equal to	117,787	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	50,694	equal to	50,694	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,507,755	equal to	1,507,755	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	8,319	< or = to	8,319	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	15,432	< or = to	15,432	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	4,700	< or = to	5,531	-831	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	0	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	3,577	< or = to	4,777	-1,200	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	117,787	equal to	117,787	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	43,940	equal to	43,940	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	203,573	equal to	203,573	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	13,255	equal to	13,255	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	2,562	equal to	2,562	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	87,600	equal to	87,600	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	None	< or = to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	None	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,224	equal to	1,224	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	1,410,301	equal to	110,923	1,299,378	FAILED	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to	0	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	179,216	equal to	179,216	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,686,613	equal to	1,686,613	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	723,884	equal to	723,884	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,592,480	equal to	1,592,480	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-252,594	equal to	-252,594	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-466,187	equal to	-466,187	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,541,020	equal to	1,541,020	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1